Complete Summary

GUIDELINE TITLE

Management of colonic polyps and adenomas.

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Management of colonic polyps and adenomas. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 4 p. [2 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Colon polyps and adenomas

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Gastroenterology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs.

TARGET POPULATION

Adult patients with colonic polyps.

INTERVENTIONS AND PRACTICES CONSIDERED

Management of colonic polyps and adenomas

- Colonoscopic polypectomy using electrocautery techniques
- Biopsy and fulguration of small polyps
- Surgical resection

Follow-up and repeat colonoscopy post-polypectomy

MAJOR OUTCOMES CONSIDERED

- Rectal cancer-specific mortality
- Colon cancer-specific mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Cost efficacy and outcome studies for different methods of diagnosis and treatment are inconclusive.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Management of Colonic Polyps

Patients undergoing colonoscopic treatment of colonic polyps require mechanical bowel preparation. Most colonic polyps can be removed via the colonoscope using electrocautery techniques. Surgical removal is indicated only when an experienced endoscopist cannot remove the polyp safely or if the polyp contains an invasive malignancy. While total excision of the polyp is desirable, small polyps (0.5 cm or less) can be treated by biopsy and fulguration, and have less than a 0.1% incidence of malignancy. Most pedunculated polyps are amenable to electrocautery snare polypectomy.

Sessile polyps larger than 2 cm usually contain villous features, have a high malignant potential, and tend to recur following colonoscopic polypectomy. If complete or safe colonoscopic resection is not possible for technical reasons, the lesion should be biopsied and the patient referred for primary surgical therapy. In cases where the lesion can be removed via the colonoscope, follow-up endoscopy should be done in 3-6 months to confirm complete resection. Residual adenomatous tissue noted at follow-up colonoscopy should be removed and another confirmatory colonoscopy performed 3 months later. Surgical resection is recommended for residual abnormal tissue at the polypectomy site after two or three attempts at colonoscopic removal.

The resected polyp must be completely examined pathologically. Histologically, adenomatous polyps can show a benign adenoma (tubular, tubulovillous or villous), carcinoma in situ, or invasive cancer. Colonoscopic removal is definitive therapy for benign adenomatous polyps or in patients having polyps with carcinoma in situ. If pedunculated polyps contain invasive carcinoma, colonoscopic removal is adequate treatment in the uniform presence of favorable prognostic indicators such as complete excision, no lymphovascular invasion, clear margins, and well-differentiated histology. A follow-up examination within three months is mandatory to confirm the presence or absence of residual or recurrent disease. Any patient with lesions not meeting these criteria should undergo elective resection of the involved segment of the colon. Should co-morbid conditions preclude operative therapy, then observation and repeat colonoscopy are appropriate.

Surgical Treatment of Colonic Polyps

A polyp that is deemed unresectable colonoscopically requires surgical extirpation. First, however, repeat colonoscopy is required so that the partially resected or flat lesion can be tattooed for localization at the time of surgery. The specimen should be opened at the time of surgery to confirm resection of the suspicious lesion. Operative mortality for elective colectomy is less than 2%, but varies with associated co-morbid conditions. Complications of colonic resection include wound infection and dehiscence, anastomotic leak, bleeding and injury to other organs, most notably the ureter.

Laparoscopic colectomy for neoplasia is considered investigational at present.

Qualifications for Treating Colonic Polyps

The qualifications of a surgeon performing any operative procedure, including colectomy and colonoscopy, should be based on training (education), experience, and outcomes. At a minimum, surgeons who are certified or eligible for certification by the American Board of Surgery or the Royal College of Physicians and Surgeons of Canada, or their equivalent should perform colectomy.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of colonic polyps will greatly reduce the risk of death from colorectal cancer. Long-term studies of sigmoidoscopy and polypectomy demonstrate a reduction of rectal cancer-specific mortality to 15% of predicted levels, while colonic polypectomy results in a two-thirds reduction in colon cancer-specific mortality.

POTENTIAL HARMS

Colonoscopic polypectomy has an overall complication rate of 1-2%, with bleeding as the most common complication. Other complications include free perforation of the bowel, microperforation, transmural electrocautery burn, pneumatosis cystoides intestinalis, splenic capsular tear, and avulsion of a mesenteric blood vessel. Many of these complications can be treated as necessary, but peritonitis or unrelenting hemorrhage requires urgent laparotomy.

Operative mortality for elective colectomy is less than 2%, but varies with associated co-morbid conditions. Complications of colonic resection include wound infection and dehiscence, anastomotic leak, bleeding and injury to other organs, most notably the ureter.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines have been written by the Patient Care Committee of the Society of Surgery of the Alimentary Tract (SSAT). Their goal is to guide PRIMARY CARE physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and

expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the range of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately but the reader must realize that clinical judgement may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Management of colonic polyps and adenomas. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 4 p. [2 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2000)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Committee Members: Thomas R Gadacz, MD (Chairman); L William Traverso, MD; Gerald M Fried, MD; Bruce Stabile, MD; Barry A Levine, MD.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates the previously issued version, J Gastrointest Surg. 1999 Mar-Apr;3(2):220-2.

An update is scheduled every two years.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Society for Surgery of the Alimentary Tract, Inc. Web site.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000.

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